

Affordable Care Act: American Health Benefit Exchanges

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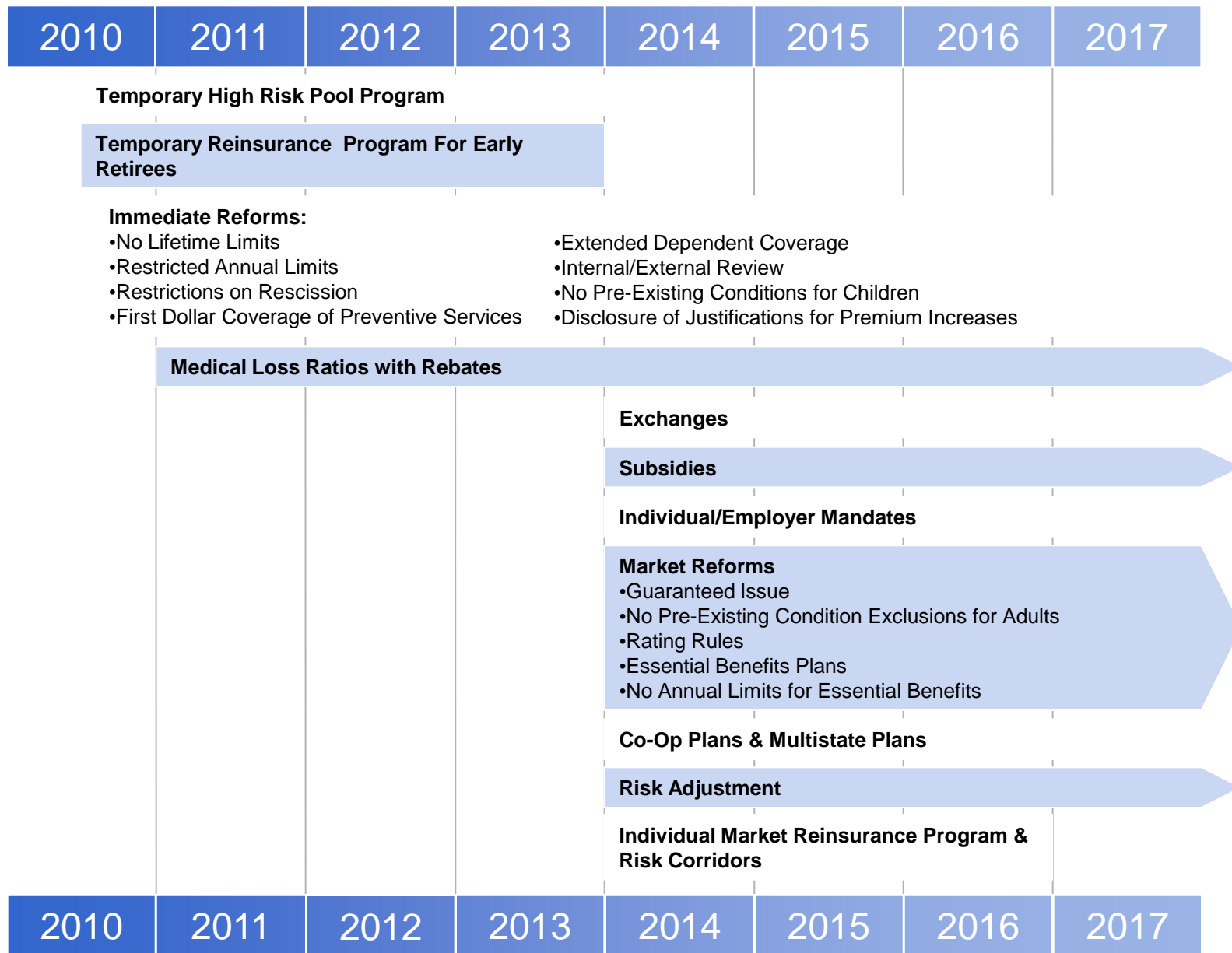
Presentation Goals

1. Brief review of the Affordable Care Act.
2. What is an exchange?
3. What does the new law require?
4. What will the new law permit?
5. What are some of the big policy questions WA will need to grapple with?
6. What lessons have been learned?

Affordable Care Act

- Reforms the insurance market so it works for everyone.
- Requires everyone to have insurance coverage.
- Establishes American Health Benefit Exchanges.
- Provides subsidies & tax credits to help people purchase insurance.
- Improves Medicare & Medicaid access & quality.
- Incentivizes patient centered care, improved quality & cost containment.
- Creates opportunities to increase & train a healthcare workforce to meet growing demand.

Health Reform Implementation Timeline



Goal of an exchange

Affordable Care Act

“Provide consumer choices and insurance competition to increase access to health insurance coverage for all Americans”

Functions of an exchange

At a minimum, an Exchange must:

- Facilitate the purchase of “qualified health plans”
- Implement procedures for the certification of qualified health plans, as determined by HHS.
- Rate qualified health plans based on quality, price, and consumer satisfaction.
- Operate a toll-free telephone hotline

Functions of an exchange

At a minimum, an Exchange must:

- Maintain Internet website with standardized information
- Determine eligibility for Medicaid, CHIP & other state health care programs
- Determine eligibility for subsidies & tax credits
- Provide a calculator to determine actual cost of coverage after subsidies.

Functions of an exchange

At a minimum, an Exchange must:

- Grant certification of individuals exempt from the purchase mandate
- Provide to the Treasury a list of exempt individuals & employees eligible for tax credit
- Provide to each employer the name of employees eligible for tax credit
- Establish a “navigator” program.

Requirements of the exchange

- Limit access to Citizens & Legal Residents
- Make exchange coverage available to individuals and small groups
- Eligible individuals may purchase any plan offered through the exchange
- Small employers choose a tier of coverage; employee chooses a plan within that tier.

Requirements of the exchange

- All plans within the exchange must be “qualified health plans:”

- ☐ Provides Essential Benefits & is licensed
- ☐ Agrees to offer at least one Silver & one Gold plan
- ☐ Agrees to charge same price in and out of exchange

- Levels of coverage:

- ☐ Bronze (covers 60% of actuarial value of benefits)
- ☐ Silver (covers 70% of actuarial value of benefits)
- ☐ Gold (covers 80% of actuarial value of benefits)
- ☐ Platinum (covers 90% of actuarial value of benefits)
- ☐ Catastrophic (high deductible plan for those under 30 or if coverage is otherwise deemed unaffordable)
- ☐ Stand alone dental plans are allowed

Requirements of the exchange

- Allow participation by multi-state plans administered through the Office of Personnel Management.
- It must provide for:
 - ☐ An initial open enrollment period
 - ☐ An annual open enrollment period
 - ☐ Special enrollment periods

Requirements of the exchange

- Consult with stakeholders in carrying out its responsibilities.
- Submit an annual report to Secretary on activities, receipts and expenditures – annual audit.

Requirements of the exchange

- Plans must disclose to the public:
 - ☐ Claims payment policies & practices
 - ☐ Periodic financial information
 - ☐ Data on enrollment & disenrollment
 - ☐ Number of claims denied
 - ☐ Rating practices
 - ☐ Cost-sharing & payments for out of network coverage
 - ☐ Enrollee rights under Affordable Care Act
 - ☐ Other information required by Secretary.

What are exchanges permitted to do?

- Operate separate or combined exchanges for the individual and small group markets
- Operate an exchange through a governmental agency or nonprofit entity
- Require plans cover additional benefits – states must assume cost of mandates
- Combine individual and small group markets for pooling purposes
- Elect to define small group as 1-50 until January 1, 2016 (definition becomes 1-100)

Inside & Outside the Exchange

- Nothing in the law precludes the sale of insurance products outside of the exchange
- Individuals may only receive subsidies in the exchange
- Carriers must consider all enrollees in all non-grandfathered plans to be members of the same risk pool – one for individual, one of small group

Addressing Risk

- Transitional Reinsurance Program
- Temporary Risk Corridors
- Risk Adjustment

Addressing Risk

Transitional Reinsurance Program

Insurance purchased by insurers from other insurers to limit the total loss an insurer would experience in case of a disaster or unexpectedly high claims.

- HHS Secretary, with NAIC to establish a mandatory reinsurance program for 2014-2016

Addressing Risk

Temporary risk corridors

Requires plans whose costs are lower than anticipated to make payments into a fund that reimburses plans whose costs are higher than expected.

- Secretary to establish risk corridors for 2014-2016 in the individual and small group markets.

Addressing Risk

Risk Adjustment

A process through which insurance plans that enroll a disproportionate number of sick individuals are reimbursed for that risk by other plans who enroll a disproportionate number of healthy individuals.

- Applies to all non-grandfathered plans in the exchange.
- Each state will operate risk adjustment based on criteria developed by the Secretary in consultation with states.

What are the policy questions WA must answer?

- What is the purpose of the exchange?
- Does WA want to establish the exchange(s) or let federal government do it?
- What is the governance of the exchange?
- What are the roles of various state agencies?
- Should there be one exchange or two?

What are the policy questions WA must answer?

- Should WA pursue a regional or subsidiary exchange(s)?
- Should the state merge the individual and small group markets for pooling purposes?
- Should the population between 133-200% FPL be served through the exchange or a BHP?
- Should the state maintain its benefit mandates?

What are the policy questions WA must answer?

- What will be the “rules of the game” for carriers operating inside and/or outside the exchange?
- Should the state begin any market transformation prior to 2014?

Exchanges: relevant dates

By March, 2011:

- Grants will be made available to assist with establishing exchanges. Grant program runs until Jan.1, 2015.

By January 1, 2013:

- HHS will determine whether the state can/may implement the exchange(s).

By January 1, 2014:

- States must have in effect state law(s) that enable the operation of exchanges as described by HHS.
- States must have in effect a reinsurance program for the individual market.

Exchanges: relevant dates

By January 2015:

- The exchange(s) must be self-sustaining.

By January 1, 2016:

- A State may choose to enter into a “health care choice compact” if the state enacts a law authorizing such action.

Beginning in 2017:

- States may allow large groups to purchase qualified health plans through the exchange.

Not a new idea

Massachusetts Connector

Independent agency governed by a 10-member board of private & public representatives appointed by the Governor or Attorney General.

- Offers health insurance to individuals and small business.
- Sets standards of coverage, “Seal of Approval”
- Provides subsidies for those that qualify.

Not a new idea

The Utah Health Exchange

Run by the Utah Office of Consumer Health Services, a state government agency

- An internet portal to assist with the purchasing of insurance coverage.
- Allows small employers to set up defined contribution plans.
- Allows premium payments from multiple sources.

Lessons learned

- Early engagement of stakeholders vital
- Establish an agreed upon purpose & goals
- Achieve a critical mass
- Guard against adverse selection
- Cost control measures key
- Provide choice without complexity
- Develop well resourced outreach & marketing program for launch